Department of Corrections
WASHINGTON STATE

CONSENT TO MEDICAL TREATMENT AND WAIVER OF LIABILITY (VISITORS)

I, _____ , being an authorized visitor under
(Name)
the Extended Family Visitor Program or other authorized program of the Department of Corrections, being eighteen (18) years of age or older, do hereby give my consent and authorize a Department of Corrections' health care provider to provide emergency medical treatment (first aid) or other non-definitive primary care as may be necessary to prevent pain, suffering, or prevent imminent threat to my life or limb as a result of an emergency situation.

I hereby do waive, relinquish, and release any and all claims, demands, or causes of action which may arise against the state of Washington, Department of Corrections, the attending health care provider and all officers and employees of the Department of Corrections accruing directly as a result of each treatment, or as an indirect result of the administration of such medical treatment which, in the discretion of the health care provider, was reasonably necessary or advisable for dealing with an emergent health care problem.

I do hereby further state that I have read the foregoing consent to treatment and waiver of liability and understand the contents thereof, and that such consent to treatment and waiver of liability are given of my own free act and deed and not under any undue influence, threat, or coercion.

_____ _____
Consenting Visitor Signature Date

Subscribed and sworn to before me this _____ day of _____ 20 _____ .

STATE OF _____)
) ss.
County of _____)

_____
(Signature)
NOTARY PUBLIC

SEAL

_____
Title

_____
Printed Name

_____
My Commission Expires

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